Washington State Department of Social & Health Services

APPLICATION AND AGREEMENT TO PARTICIPATE IN THE TAKE CHARGE FAMILY PLANNING PROGRAM

(Application and Agreement)

IMPORTANT: Must be a current Medicaid Family Planning provider.
Read all attached materials before completing. Type or print clearly in ink.
Signature of authorized official is required.

For State Use Only

Date Received: _____

Date Approved: _____

Date Returned: _____

NAME OF APPLICANT (must be same name as used for current Medicaid Family Planning Provider No.)			TELEPHONE NUMBER
AGENCY/CORPORATION			FAX NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE
CONTACT PERSON FOR THIS APPLICATION	TITLE		TELEPHONE NUMBER
CURRENT MEDICAID FAMILY PLANNING PROVIDER NUMBER (To be registered for TAKE CHARGE)			TAX ID NUMBER

List below all service sites at which TAKE CHARGE services will be provided. List all service sites and addresses that are applicable under this Application and Agreement. Please attach a separate sheet of paper for any additional sites not listed below.

SERVICE SITE NAME (If different from above)			TELEPHONE NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE
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I. ADMINISTRATIVE PRACTICES

Please read the following statements carefully and indicate whether or not you agree to adhere to these terms. Agreement with each of these statements is a requirement for participation in the TAKE CHARGE program.

	Yes	No
1. I agree to provide services to eligible clients under the TAKE CHARGE program in accordance with state and federal law.	☐	☐
2. I agree to screen clients for eligibility for the TAKE CHARGE program, on an annual basis, according to instructions issued by MAA.	☐	☐
3. I agree to make my administrative files, billing, and medical records pertaining to the TAKE CHARGE program available at reasonable times for inspection, auditing, monitoring, or evaluating by State auditors/quality improvement staff for a period of five years from the end of the fiscal year in which the client encounter took place.	☐	☐

II. EVALUATION AND RESEARCH

Please read carefully the following statements about the TAKE CHARGE research and evaluation responsibilities. Indicate whether or not you agree to adhere to these responsibilities. Agreement with each of these statements is a requirement for participation in the TAKE CHARGE program.

	Yes	No
1. I agree to cooperate with and participate in the research and evaluation effort of the TAKE CHARGE program as determined by DSHS.	☐	☐
2. I agree to be randomly assigned to either a control group or an intervention group in the research and evaluation effort of the TAKE CHARGE program.	☐	☐
3. I agree to collect client-specific information on all TAKE CHARGE clients and make available such information for use in the evaluation of the TAKE CHARGE program.	☐	☐
4. I agree, if assigned to an intervention group, to do "Intensive Follow up Services (IFS)" to TAKE CHARGE clients.	☐	☐
5. I agree, if assigned to an intervention group, to collect additional information, as specified by DSHS, on my TAKE CHARGE clients and make available such information for use in the evaluation of the TAKE CHARGE program.	☐	☐

III. CLINICAL PRACTICE STANDARDS

Please read carefully the following statements about the TAKE CHARGE clinical practice standards and indicate whether or not you agree to adhere to these terms for TAKE CHARGE clients. Agreement with each of these statements is a requirement for participation in the TAKE CHARGE program.

CORE ELEMENTS

A. <u>Informed Consent</u>

	Yes	No
1. The informed consent process will be provided to all TAKE CHARGE clients verbally and supplemented with written materials in a language the client understands.	☐	☐
2. Consent will be required from only the individual client receiving TAKE CHARGE services, including minors, except as otherwise provided by law.	☐	☐
3. All clients must sign consent forms for any invasive procedures performed and be told of their freedom to withdraw consent at any time.	☐	☐
4. Clients requesting sterilization will sign an appropriate State sterilization consent form, and the procedure will take place within the required time frame based on the date of the client's signature.	☐	☐
5. Participation in and consent for services under the TAKE CHARGE program will be voluntary and without bias or coercion to accept methods, procedures, or otherwise participate in family planning services and research.	☐	☐
6. A copy of the TAKE CHARGE Family Planning Patient Rights statement will be provided to all clients and posted in a prominent place at the site of clinical services.	☐	☐

B. Confidentiality

	Yes	No
1. Services will be provided in a manner that respects the privacy and dignity of the individual.	☐	☐
2. All clients will be informed of the confidentiality of services and assured that their identity will not be revealed without written permission, except as provided by law.	☐	☐
3. All personal client information will be treated as privileged communication and held confidential, and not be divulged without individual written consent.	☐	☐

C. Availability of Birth Control Methods Options

	Yes	No
1. All FDA-approved contraceptive methods and their use consistent with recognized medical practice standards, including sterilization procedures, will be made available to clients.	☐	☐
2. If the clinicians represented by the Agreement lack the specialized skills to provide IUDs, Norplant, and male and female sterilization, or there is insufficient volume to ensure and maintain high skill level for these procedures, clients selecting these methods will be referred to another qualified provider with whom there is an established referral arrangement.	☐	☐
3. A client's selection of contraceptive method(s) will be based on client preference in conjunction with medical findings.	☐	☐

D. Cultural and Linguistic

	Yes	No
1. All services will be provided in a culturally sensitive manner and communicated in a language understood by the client.	☐	☐

E. Access to Care

	Yes	No
1. Services listed in the scope of care will be provided without cost to eligible TAKE CHARGE clients.	☐	☐
2. Appointments for established clients will be available within a reasonable time period, generally less than 3 weeks. New clients who cannot be seen within this time period will be referred to other qualified TAKE CHARGE providers in the area. Vulnerable clients will be given priority in obtaining same day services or seen as soon as possible.	☐	☐
3. Those contraceptive methods, supplies and treatment for sexually-transmitted diseases (STDs) listed in the scope of care will be provided in conjunction with TAKE CHARGE services and will be available at the site of clinical services, or by prescription without any cost to the eligible client.	☐	☐
4. Referrals to local resources will be made for clients when needed medical and psycho social services are beyond the scope of the applicant, including, but not limited to, domestic violence and substance abuse-related services.	☐	☐
5. All services must be provided to eligible clients without regard to gender, age (except for sterilization), race, marital status, disability or sexual orientation.	☐	☐

F. Clinical and Preventive Services

	Yes	No
1. The scope of family planning and clinical preventive services for female clients shall be consistent with recognized medical practice standards and will include: counseling and education for unintended pregnancy risk reduction services; a comprehensive health history; physical examination and appropriate laboratory tests; provision of contraceptive methods/procedures including sterilization, STD diagnosis and treatment service; and pregnancy testing service.	☐	☐
2. The scope of family planning services for male clients shall be consistent with recognized medical practice standards and will include counseling and education for risk reduction services, non-prescriptive contraceptive barrier methods/supplies, sterilization, and TAKE CHARGE related STD diagnosis and treatment.	☐	☐

G. Education and Counseling Services

	Yes	No
1. All TAKE CHARGE clients will receive Family Planning Education, Counseling and Risk Reduction Services outlined in the TAKE CHARGE Program Billing Instructions.	☐	☐
2. As part of an annual visit, all clients will be provided with adequate information to make an informed choice about family planning methods, including: a verbal and written description of all FDA-approved methods including effectiveness, duration, side effects, complications, medical indications and contraindications, and social and physical advantages and disadvantages; a description of the implications and consequences of sterilization procedures; specific verbal and written instructions for care, use and possible danger signs for the selected method(s); and written information about how to obtain services for family planning related complications or emergencies.	☐	☐
3. All education and counseling for risk reduction sessions will be provided in a way that the client will understand and which will promote positive reproductive behavior.	☐	☐
4. All clinician, education and other staff providing education and counseling services will be knowledgeable about the psycho social and medical aspects of reproductive health, and principles of behavioral change and counseling techniques, including interviewing and communication skills.	☐	☐

I certify that I am duly authorized to commit all Service Sites, Provider Numbers and Practitioners specified in this Application and Agreement to the Administrative Practices and Clinical Practice Standards incorporated into this Application and Agreement subject to change only upon written notification from MAA. I understand that providers who do not provide services consistent with the Standards may be disenrolled as a provider from the TAKE CHARGE program. I certify that the above information is true, accurate, and complete to the best of my knowledge. I understand that incorrect or inaccurate information may affect my eligibility to participate in the "TAKE CHARGE" program and receive Medicaid reimbursement and that I must report changes to the above information to the Medical Assistance Administration, Division of Program Support, Family Services Section, TAKE CHARGE Program Manager.

AUTHORIZED AGENT'S NAME (Official/physician owner with the authority to bind the agency/corporation)	TITLE
AUTHORIZED AGENT'S ORIGINAL SIGNATURE	DATE

Return Completed Form To:

Medical Assistance Administration
Division of Program Support
TAKE CHARGE Program Manager
PO Box 45530
Olympia WA 98504-5530